PREVENTION OF RSI: PROGRAM OVERVIEW

AORN is proud to introduce a complimentary education and recognition program for perioperative teams to prevent near misses and consequences of unintentionally retained surgical items (RSI).

- ☑ **Demonstrate team commitment to a culture of safety**
- ☑ **Understand actions necessary to eliminate this surgical never event**
- ☑ **Foster a collaborative work environment**
- ☑ **Earn public recognition as a Center of Excellence in Surgical Safety**

This evidence-based program is a comprehensive approach to reducing risks. It uses immersive technology and scenarios to educate and train team members and incorporates analysis and quality improvement actions to enhance patient safety. Your facility can earn public recognition and confirm your commitment to the highest levels of patient safety as an **AORN Center of Excellence in Surgical Safety: Prevention of RSI.**

A PREVENTIVE APPROACH AGAINST RSI

Every day there are risks and challenges in the OR, yet you remain dedicated to the welfare of others. You deserve peace of mind that your team is set up for success and your operating room is safe for patients and staff.

Through this evidence-based education program, perioperative teams will learn:

- Root causes of RSI and learn multiple approaches to mitigate risks
- Human behaviors and environmental influences that lead to unintended RSI
- Procedures for accurately counting surgical items
- Strategies to increase compliance with counting processes before, during, and after procedures
- Guidelines for reconciling discrepancies, including the use of adjunct technologies to augment manual counts

Sponsored by Stryker through the AORN Foundation

If you need additional assistance with securing leadership support, developing the business case, and/or preforming a gap analysis, contact RSImanager@aorn.org

AORN does not endorse or support any manufacturer's product.

AORN Center of EXCELLENCE in Surgical Safety

PREVENTION OF RSI: PROGRAM OVERVIEW

Step 1: Meet the Prerequisites
Before beginning the initiative, the facility must commit to eliminating unintentionally retained surgical items and secure leadership support.

Step 2: Identify the Facility Coordinator & Implementation Team
The individuals who comprise the team are responsible for starting and sustaining the initiative to eliminate unintentionally retained surgical items.

Step 3: Develop an Action Plan for Implementation of the RSI Prevention Program
When developing an action plan, consider who will be affected and how, determine what resources will be needed, identify possible barriers and ways to overcome them, specify how you will measure progress and success, and develop your program timeline.

Step 4: Perform the Gap Analysis
The gap analysis evaluates the number of RSIs and near misses at your facility in the past five years, reviews the root cause, and assesses the usage of current equipment.

Step 5: Assign Education
Education is the cornerstone of the program and includes an online pre-test, modules, scenario-based immersive technology, simulations, and a post-test. The education component is designed for all perioperative team members.

Step 6: Audit and Monitor Compliance
The facility coordinator will conduct an audit monitoring surgical procedures to determine compliance with the facility's prevention for retained surgical items policy whenever a surgical count is indicated by direct observation, using the Compliance Audit Tool, and monitoring weekly for three months.

Step 7: Apply for Recognition
Final recognition is based on your facility's completion of the education components and achieving 90-100% compliance rate by week 12.

Step 8: Re-Certify
The recognition is a three-year designation. After three years, you may reapply for recognition.